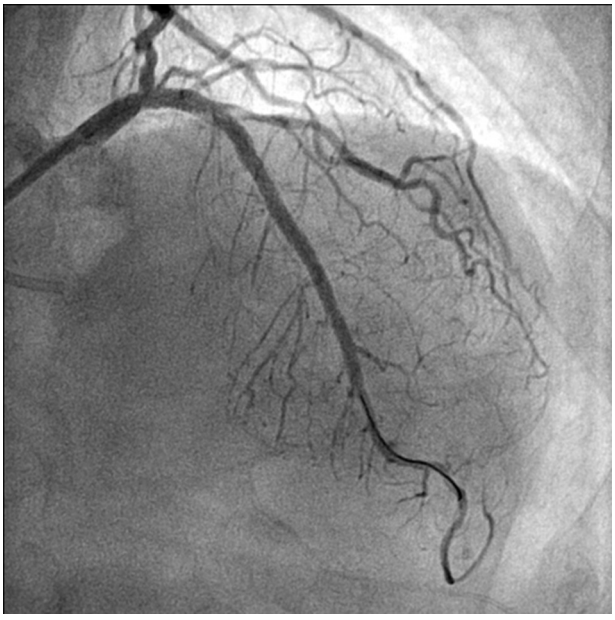

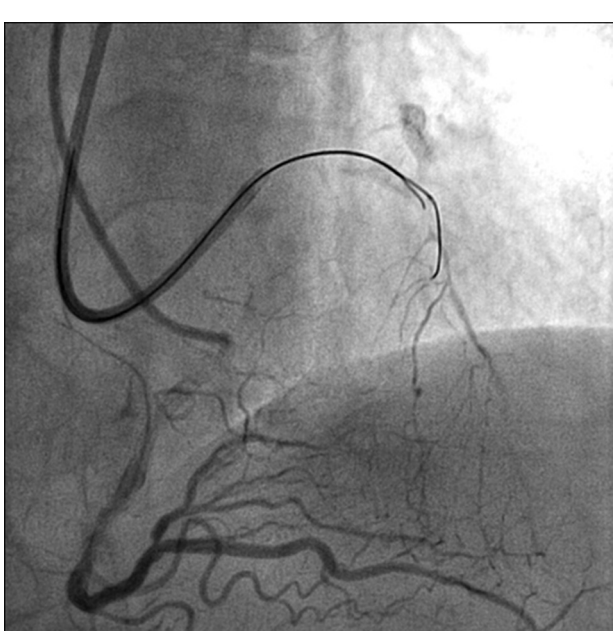

Case Summary. In this case, selection of Crusade microcatheter (MC) was directly linked to the successful opening of this CTO lesion by antegrade approach. In addition to serve as an ordinary MC (support the wire from buckling, facilitate guidewire exchange and shaping), Crusade's two parallel channels could be ideal for executing two wire techniques. As demonstrated by our case, it is the optimal device to facilitate puncturing proximal cap at a different location. It prevents guidewires from twisting in parallel wire technique. It can be used to puncture ostial CTO of a side branch. Although not performed in this case, wiring through the stent struts can be optimized by Crusade MC.

TCTAP C-112

Broken Balloon Fragment in the Coronary: Retrieving Without Snaring

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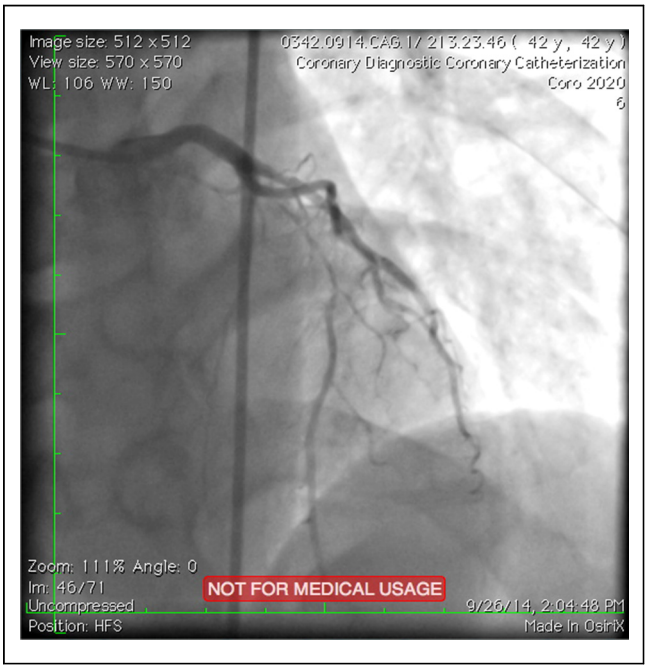
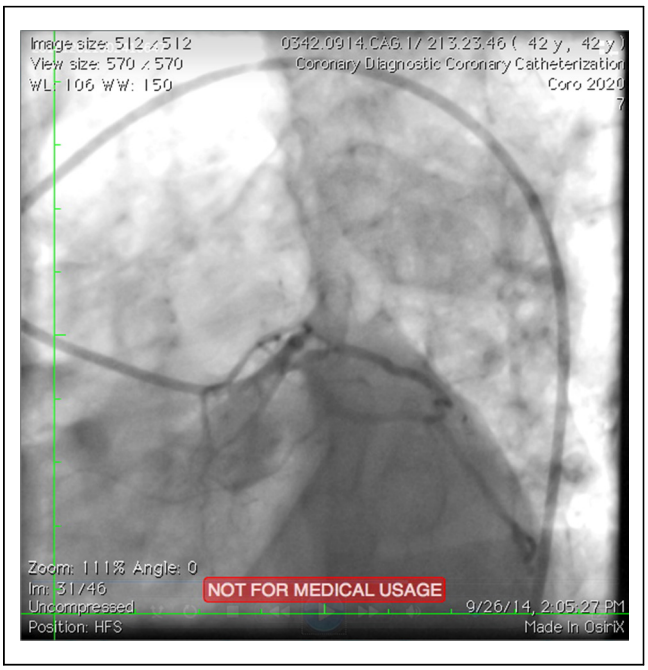
[CLINICAL INFORMATION]

Patient initials or identifier number. Mr S, 377415

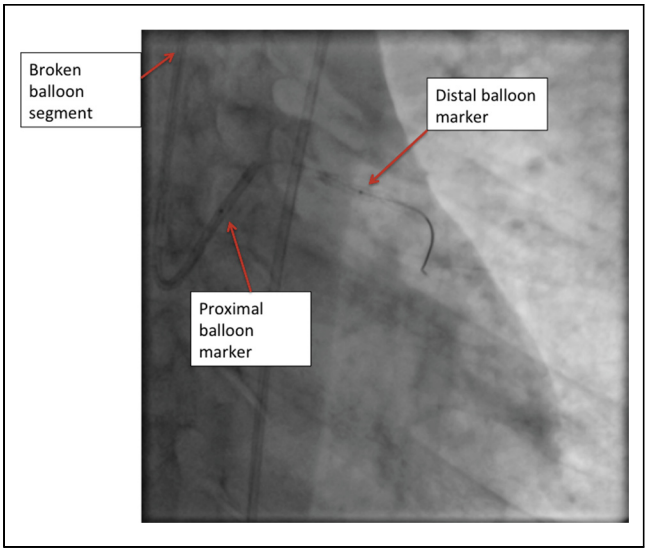
Relevant clinical history and physical exam. A 42 years old male with chronic stable angina. Risk factors: diabetes and smoker. No history of MI. Good LV function. Normal renal function.

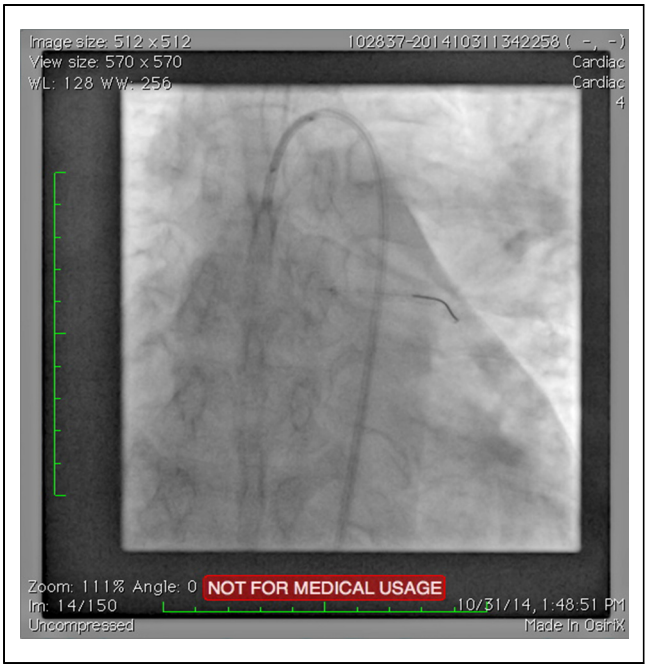
Relevant catheterization findings. Patient underwent elective coronary angiography and subsequent PCI in another hospital. The coronary angiography showed severe LAD long lesion from the ostial to mid segment with moderate calcification. Ramus intermedius also showed moderate disease. Lcx and RCA showed no significant stenoses.





distal tip of the balloon reached the distal end of GC and inflated the balloon at high pressure up to 20 atm to ensure that the NC balloon trapped the fragmented segment in the GC properly. Then we pulled the whole system (GC+wire+NC balloon) with fluoroscopy guidance making sure the broken fragment was pulled along with the system. We could see that the whole system was retrieved completely.





[INTERVENTIONAL MANAGEMENT]

Procedural step. PCI was initially performed at another hospital with femoral approach: XB 3.5/7F GC, Runthrough NS Floppy. Pre-dilatation with a 2.0/20 balloon. Insertion of a 3.0/33 mm DES to the LAD met resistance probably due to calcification in LAD and it was decided to implant the stent at LM to LAD.After stent implantation the stent balloon could not be retrieved and forceful retrieval resulted in balloon segment fracture inside the coronary. The patient complained of chest pain and promptly referred to our center for further management and emergency surgery if necessary. In our hospital patient was alert, complaining mild chest discomfort. The GC was still in place through the sheath in femoral artery. Fluoroscopy showed GC was still engaged in the LM, broken balloon fragment visualized in LM-LAD, with the proximal segment was still in the GC. We inserted a 2.5/20 mm non-compliant balloon into the GC without wiring until the

Case Summary. Recannulation of LCA with XB 3.5/6F and subsequent coronary angiography showed the stent was in place in LM-LAD without any apparent thrombus nor dissection, TIMI Flow III to distal LAD. It was decided not to intervene LAD further and planned to do repeat angiography afterward.

Conclusion: Forceful retrieval of devices could lead to disastrous consequences, in this case a broken balloon fragment. If the fragment is still inside the GC it is possible to retrieve it using a simple trapping technique with a non-compliant balloon without the need of additional devices such as a snare.